Roe (J. O.)

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THE TREATMENT OF DESEASED TONSILS WHEN UNATTENDED WITH HYPERTROPHY.*

By JOHN O. ROE, M. D.

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It is my purpose in this short paper to call attention to some chronic diseased conditions of the tonsils not characterized by hypertrophy. Such diseased conditions have frequently proved, in my experience, to be of marked clinical importance and to demand appropriate and thorough treatment.

The group of glands between the pillars of the fauces which constitute the faucial tonsils is, as has been stated by Dr. Bosworth,† so small in size when in their normal condition as to be scarcely perceptible on ordinary inspection. The condition of moderate prominence of the tonsil that is commonly seen is not a normal condition, although the tonsils may not be so much diseased as to give rise to any particular disturbance. It is a fact, however, that the tonsils may be and very often are so extensively diseased as to give rise to well-pronounced and often serious local and general disturbances, while at the same time they

* Read before the American Laryngological Association at its eleventh annual congress.

† "The Function of the Tonsils, with some Practical Suggestions in Regard to their Diseases," Congrès périodique international des sciences médicales, Copenhague, "Compte-Rendu," vol. iv, p. 54.

retain or may be reduced to about the same size as in health, and it is to this condition that the writer wishes to direct particular attention.

This condition of the tonsils has not only not received the attention it demands, but is not even mentioned by the majority of writers on tonsillary diseases, although it has not remained entirely unrecognized.

In conjunction with "Chronic Follicular Tonsillitis," Dr. Cohen* recognizes the fact that the tonsils may be quite extensively diseased without being in a condition of hypertrophy, and Dr. Harrison Allen† has reported five cases of tonsillary disease producing well-marked and peristent symptoms in which the tonsils were small and so hidden behind projecting faucial pillars as to remain unnoticed.

A similar condition has been alluded to by Mr. Lennox Browne‡ in his brief description of "Chronic Lacunar Tonsillitis," and a case is reported by him similar to those reported by Dr. Allen. Dr. Maxwell,§ of Jacksonville, Fla., has practically recognized certain conditions of the tonsils that form the subject of this paper, but the title of his paper, "Ablation of Tonsils when Smaller than Natural," is misleading, for the reason that it presupposes or implies that tonsils are normally prominent and well-pronounced bodies.

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* "Diseases of the Throat and Nasal Passages," 2d edition, p. 222.

† "The Tonsils and Follicular Irritation," "Medical News," Philadelphia, vol. xli, p. 31.

‡ "The Throat and its Diseases," London, 1887, 2d edition, p. 335.

§ "The Medical and Surgical Reporter," Philadelphia, 1889, vol. lx, page 196.

Wagner,* in describing chronic catarrh of the lacunæ in conjunction with atrophy of the tonsils, says: "The cyst-like dilatations of the lacunæ (like comedones) have a clinical importance from the fact that their contents act irritatingly on the contiguous parts, either mechanically or chemically. In this way are produced, and usually repeatedly, the various kinds of tonsillitis, and especially intratonsillar and peritonsillar abscess."

It is interesting to note that for these conditions, which are capable of producing so much mischief, Wagner recommends no treatment whatever, for the reason, he says, that they are seldom detected during life. It is a traditional and a very generally accepted idea that only hypertrophied tonsils require treatment, but the fallacy of this idea will be apparent by a careful consideration of these obscure abnormal conditions of the tonsils, which so often escape observation.

The primary and most common form of disease of the tonsils is hypertrophy. In children it is rare that we find any other than the hypertrophied form of tonsillary disease; but in adults other diseased conditions of the tonsils are of frequent occurrence. It is a recognized fact that hypertrophied tonsils in children become smaller when adolescence is reached; and it is also the common belief that the subsidence of these tonsils indicates a return, not only to their normal size, but to a normal condition. But a careful examination will readily show this belief to be a fallacy; and

* Von Ziemssen's "Cyclopædia of the Practice of Medicine," American edition, vol. vi, p. 971.

it is not infrequently the case that these small tonsils will give quite as much annoyance to the patient as he experienced from the tonsils in their enlarged condition. It is almost invariably the case that these small but diseased tonsils in adults follow as a sequal the hypertrophic tonsils of children, and exemplify the importance of removing from the throats of children all tonsils attended by any considerable degree of hypertrophy. All chronic diseased tonsils in adults almost invariably follow a condition of hypertrophy in childhood or youth; but in exceptional cases hypertrophy may not precede the diseased conditions under consideration.

The two forms of chronic diseased tonsils which remain after the subsidence of hypertrophy, or which may exist independent of hypertrophy, are—

1. A chronic disease of the crypts and lacunæ of the tonsil.

2. A fibroid degeneration of the stroma of the tonsil or a cicatricial formation at the base of the tonsil.

The first condition is the result of chronic follicular inflammation of the tonsil, and is almost invariably associated with chronic follicular pharyngitis. The most common form of this is attended by the destructive degeneration of hypertrophied tonsils in children, and is distinctly a diseased condition of the follicles of the tonsils. This slow but progressive destruction of the follicles of the tonsils is the exciting cause of the frequent attacks of suppurative inflammation, which

often attends this condition, and which is easily induced by slight exposures or deranged condition of the system. These degenerate tonsils often have the appearance of being hypertrophied when the crypts and lacunæ are filled with the *débris* of the degeneration, which frequently has a very offensive odor and causes the person to have a very bad-smelling breath.

It is not uncommon to find the surface of diseased tonsils studded with white spots which mark the openings of the lacunæ. These white spots are caused by the material discharged from the crypts and lacunæ of the tonsils and is the chronic inflammatory exudate resulting from the disease of the tonsil. On squeezing this out, it will be found to be of a soft, cheesy consistence, to resemble very much the contents of comedones, and to have an offensive odor, which may be more fully brought out by crushing it. It is usually the case that much deposit of this material is associated with more or less hypertrophy of the stroma of the tonsil, for when the stroma and the follicles have undergone further degeneration, this substance is poured out in a fluid form.

The second condition is also the result of the follicular disease, except that, simultaneously with the degeneration of the lymph follicles, there is a deposit of fibrous material in the stroma. The cicatricial formation at the base of the tonsils is the result of the frequent attacks of suppuration around the base of tonsils which is induced by the follicular disease.

The reason for these conditions being so frequently overlooked is that they usually give rise to little or no

discomfort to the patient which he refers to the tonsils themselves; because the disturbances to which they do give rise are usually located in other parts, and are of a reflex character. Another reason for their being so readily overlooked is that, on examining the throat, the diseased condition of the tonsil generally looked for is hypertrophy. This being absent, the real disease of the tonsil remains unsuspected.

The chronic disease of the interior of the tonsil, even when it is attended with considerable discharge, is frequently undetected for the reason that the discharge is so readily cleared away by swallowing or drinking. In other cases the tonsil may be partially or completely hidden behind large and projecting faucial pillars. In the latter case the free exit of the tonsillar discharge may be prevented by the overlapping pillars, thereby causing a distension and dilatation of the crypts and a bulging of the pillars over the tonsils.

In these cases the anterior pillars should be drawn forward with a blunt hook. For this purpose an aneurysm needle or a plain palate retractor is very conveniently adopted. The act of gagging also assists materially in the examination by throwing the tonsils inward and forward, thus exposing them completely to view.

In all cases of obscure disease of the throat the tonsils should be carefully examined. The enlarged crypts and lacunæ may be explored with a probe for enlarged pouches which are so often filled with muco-purulent discharge; and this discharge can be readily

demonstrated by simply squeezing it out with the finger. The formation in the tonsil and around its base of cicatricial tissue, which is very often the exciting cause of throat irritation, can also be readily detected with the probe and finger, and can usually be suspected by simply a careful inspection.

The local irritation produced by the diseased condition above described is manifested in a variety of disturbances about the throat and head. The association of this diseased condition with follicular inflammation of the pharynx renders a removal of the abnormal condition of the tonsils a necessity, before the latter can be cured. Also, disease of the faucial tonsils is frequently the exciting cause of diseased condition of the other so-called tonsils—the lingual and the pharyngeal tonsils.

It is also frequently manifested in irritation of the larynx and hoarseness; and it is not infrequent that cicatricial formations in and about the tonsils will produce neuralgia of the face, neck, and more or less frequent or persistent neuralgic affections of the ear.

The necessity of treatment of these diseases is therefore evident, not only from the existence of the disease itself, but from the liability of its becoming aggravated by the slightest cause, and also from the accompanying disturbances which it almost invariably produces. The method of treatment in these cases is always local, except in those conditions of the tonsil that depend upon specific disease, or those conditions of chronic inflammation of the circumcellular tissue of the tonsil that accompany rheumatic conditions.

Local applications of medicinal substances in these conditions of the tonsils are practically useless. The application of caustics, such as the Vienna or London paste, may be used in the first form of the disease described, in which the tonsil itself is soft and flabby. In the case of the fibrous or cicatricial formations, the efficacy of the paste is not so great, as the tissue is not readily destroyed by it. The galvanic cautery, which is sometimes employed for the removal of hypertrophied tonsils, may also be employed in these cases. It is, however, far more efficacious in the treatment of disease of the lacunæ and crypts, for the reason that the application of the galvanic cautery tends further to increase the formation of cicatricial tissue.

The treatment *par excellence* in all cases is that of ablation with the knife. In the case of diseased crypts, they may be laid open with a bistoury, and the interior of the crypt thoroughly cauterized with chromic acid or a solid stick of nitrate of silver, or the silver fused on a platinum probe, as proposed by Dr. Cohen. The best plan, however, in these cases is, according to my experience, that of excision. In such case, however, the amygdalotome can not be employed. The method of removing these tonsils is simply to grasp the tonsil with a double tenaculum, draw it forward from its bed, and remove a portion at a time. It is rarely advisable to attempt to remove the whole mass at one cut, for these tonsils are so often attached to the pillars of the fauces that wounding the pillars is liable to take place if care is not exercised. The plan which I adopt in these cases is, first, to anæsthetize the parts as

thoroughly as possible with cocaine. This has a double advantage, in that it not only renders the operation less painful, but decreases the liability to hæmorrhage. Then with a double tenaculum and a curved blunt-pointed tonsil-knife to remove small portions of the tonsil until all the diseased mass is thoroughly extirpated, usually leaving a deep excavation between the pillars of the fauces. In the case of a cicatricial formation, it should be removed as thoroughly as practicable. In some cases of chronic disease of the crypts of the tonsils it is advisable to remove the outer portion of the tonsil completely, thus exposing the interior of the crypt, which can be cauterized thoroughly.

In all cases, however, the complete extirpation of the gland when possible is far preferable to any other form of treatment, as nothing but a surface of healthy tissue is left, which heals quickly and permanently. In no instance has the writer had any troublesome hæmorrhage in these operations. This is doubtless due to the fact that in these cases the nutrient vessels going to the tonsils are small or are not so distended as they are when the tonsils are in a condition of hypertrophy.

A large number of cases illustrating the foregoing observations could be cited, but, as the recital of cases is tedious, I will simply state that in every instance excision of these small but diseased tonsils has resulted in a complete cure of the tonsillary disease, and entire relief from all the attendant symptoms of local disturbance and reflected irritation.

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